GUIDE

To Health Insurance for People with Medicare

1990

Some Basic Things You Should Know

Hints on Shopping for Private Health Insurance

Types of Private Health Insurance

What Medicare Pays and Doesn't Pay

Developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration of the U.S. Department of Health and Human Services.

#1

IMPORTANT MESSAGE

THE MEDICARE PROGRAM HAS BEEN SIGNIFICANTLY CHANGED FOR 1990 AND THIS WILL AFFECT HOW YOUR PRIVATE HEALTH INSURANCE COVERAGE IS NOW COORDINATED WITH MEDICARE. YOUR MEDICARE BENEFITS WERE CHANGED AS OF JANUARY 1, 1990, AFTER CONGRESS VOTED IN LATE 1989 TO REPEAL MOST OF THE PROVISIONS OF THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988 (PUBLIC LAW 100-360). THE CATASTROPHIC LAW EXPANDED MEDICARE'S BENEFITS AND ADDED SOME NEW ONES. SOME OF THESE BENEFIT CHANGES WERE IMPLEMENTED IN 1989 AND OTHERS WERE TO HAVE TAKEN EFFECT IN 1990 AND SUBSEQUENT YEARS. THEY NOW HAVE BEEN CANCELLED ALONG WITH THE ASSOCIATED SURCHARGES ASSESSED BENEFICIARIES TO PAY FOR THEM. IN REPEALING THE ACT, CONGRESS RESTORED THE MEDICARE COVERAGE THAT WAS IN EFFECT PRIOR TO JANUARY 1, 1989 (SEE PAGES 17 THROUGH 30).

DUE TO THIS LATEST RESTRUCTURING OF MEDICARE COVERAGE IT IS EXPECTED THAT MEDICARE SUPPLEMENT INSURANCE (MEDIGAP) BENEFITS AND PREMIUMS WILL BE ADJUSTED ACCORDINGLY. CONSEQUENTLY, YOU SHOULD RE-EVALUATE YOUR INSURANCE NEEDS BASED ON YOUR PRESENT MEDICARE COVERAGE, FINANCES AND THE STATUS OF YOUR HEALTH. IF YOU DISCONTINUED YOUR MEDIGAP POLICY IN 1989 YOU MAY HAVE THE OPTION OF REINSTITUTING THAT COVERAGE WITHOUT PENALTY UNDER CERTAIN CIRCUMSTANCES (see page 5).

NOTICE

LISTED IN THE BACK OF THIS PAMPHLET ARE THE ADDRESSES AND TELEPHONE NUMBERS OF EACH OF THE STATE AGENCIES ON AGING AND THE STATE INSURANCE DEPARTMENTS. THEY ARE AVAILABLE TO ASSIST YOU WITH ANY QUESTIONS YOU MAY HAVE ABOUT PRIVATE INSURANCE TO SUPPLEMENT MEDICARE, OR SO-CALLED "MEDIGAP POLICIES. SUSPECTED VIOLATIONS OF THE LAWS GOVERNING THE MARKETING OF THESE POLICIES SHOULD BE REPORTED TO YOUR STATE INSURANCE DEPARTMENT OR FEDERAL AUTHORITIES. THE FEDERAL TOLL-FREE TELEPHONE NUMBER FOR REGISTERING SUCH COMPLAINTS IS:

1-800-888-1998.

AFTER APRIL 30, 1990, CALL:

1-800-638-6833

1-800-492-6603 (In Maryland)

SOME BASIC THINGS YOU SHOULD KNOW--Medicare pays a large part of your health care expenses, but it does not pay them all. There are limits on Medicare payments for some covered medical services, supplies and equipment. You also must pay certain amounts called deductibles and co-payments.

There are some services which are not covered either by Medicare or most private insurance. For example:

- **Custodial care in a nursing** home, or any other setting, is not covered by Medicare or most private insurance policies on the market today (See page 15).

- **Medicare and most private health** insurance policies generally pay only a specified percent of the Medicare approved amount. You pay the rest, including any charges in excess of those approved by Medicare. To avoid excess charges, ask your doctors or medical suppliers whether they participate in Medicare or accept assignment of Medicare benefits. Those who accept assignment agree to submit claims directly to Medicare and to accept as payment in full no more than the Medicare-approved amount. Doctors and suppliers who sign Medicare participation agreements accept assignment on all Medicare claims. Others may do so on a case-by-case basis (See page 28). All physicians and qualified laboratories must accept assignment for covered clinical diagnostic laboratory tests.

Insurance to supplement Medicare, commonly called "Medigap" insurance, is not sold or serviced by the Federal or State governments. Do not believe advertising or agents who suggest that Medicare supplement insurance is a government-sponsored program.

Before buying insurance to supplement Medicare, familiarize yourself with your Medicare benefits. Once you have a good understanding of them you will be better prepared to determine your health insurance needs. Pages 17 through 30 explain your Medicare coverage. Please review them carefully.

DO YOU NEED PRIVATE HEALTH INSURANCE IN ADDITION TO MEDICARE? NOT EVERYONE DOES.

- **If you are a Medicare** beneficiary enrolled in a prepayment plan, such as a health maintenance organization (HMO) or competitive medical plan (CMP), which has a contract with Medicare, you may not need a Medicare supplement policy (See page 12).

- **Low-income people who are** eligible for Medicaid generally do not need additional insurance. Individuals who are eligible for regular Medicaid benefits qualify for certain health care benefits beyond those covered by Medicare, such as long-term nursing home care.

- **Limited financial assistance is** available through Medicaid for paying a share of acute care costs for certain low-income elderly and disabled

Medicare beneficiaries. If your annual income is below the national poverty level and you do not have access to many financial resources, you may qualify for government assistance in paying Medicare monthly premiums and at least some of the Medicare deductibles and co-payments. The national poverty income levels for 1990 will be announced in February 1990. In 1989 the limits were $5,980 for one person and $8,020 for a married couple. The maximum annual income for qualifying for assistance may vary by State. If you qualify, this financial assistance is available through your State's medical assistance (Medicaid) office. For further information contact your state or local social service agency and ask about the "Qualified Medicare Beneficiary" benefit.

- **Whether you need health** insurance to supplement Medicare is a matter you may want to discuss with someone you know who understands insurance and your financial situation. The best time to do this is before you reach age 65. Some State insurance departments offer health insurance counselling services. You may want to check to determine whether your State does.

TIPS ON SHOPPING FOR HEALTH INSURANCE

Shop carefully before you buy. Policies differ widely as to coverage and cost, and companies differ as to service. Contact different companies and compare the policies carefully before you buy.

Don't Buy More Policies Than You Need. Duplicate coverage is costly and unnecessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverages.

Consider Your Alternatives. Depending on your health care needs and finances, you may want to consider continuing the group coverage you have at work; joining an HMO, CMP or other prepayment plan; or buying a Medicare supplement policy (See pages 9 through 16).

Check For Preexisting Condition Exclusions. In evaluating a policy, you should determine whether it limits or excludes coverage for existing health conditions. Many policies do not cover health problems that you have at the time of purchase. Preexisting conditions are generally defined as those conditions for which medical advice was given or treatment was recommended by or received from a physician before the effective date of your coverage under an insurance policy.

Most State laws require Medicare supplement policies to cover preexisting conditions after the policy has been in effect for 6 months.

Don't be misled by the phrase "no medical examination required." If you have had a health problem, the insurer might not cover you for expenses connected with that problem.

Beware of Replacing Existing Coverage. Be suspicious of a suggestion that you give up your policy and buy a replacement.

The new policy may impose waiting periods or have exclusions or waiting periods for preexisting conditions. On the other hand, don't keep inadequate policies simply because you have had them a long time. You don't get credit with a company just because you've paid for a policy many years.

Be Aware of Maximum Benefits. Most policies have some type of limit on benefits. They may restrict either the dollar amount that will be paid for treatment of a condition or the number of days of care for which payment will be made. Some insurance policies pay less than the Medicare approved amount (or nothing) for hospital outpatient medical services or services in a doctor's office than they pay for the same services provided to a hospital inpatient.

Check Your Right to Renew. Beware of policies that let the company refuse to renew your policy on an individual basis except for failure to pay the required premiums. These policies provide the least permanent coverage.

Most policies cannot be canceled by the company unless all policies of that type are canceled in the State. Therefore, these policies cannot be canceled because of claims or disputes. Some policies are guaranteed renewable for life. This means that although your insurance premiums may be adjusted from time to time, the insurance company cannot cancel your coverage. Policies that can be renewed automatically offer added protection.

Reinstituting Medigap Coverage. If you formerly had coverage under a Medicare

supplement policy but discontinued it during 1989, you may have the right to reinstitute that coverage. The new law which repealed the catastrophic coverage act directs that Medicare beneficiaries who had Medicare supplement policies in effect on December 31, 1988, and who terminated them during 1989 must be notified by their insurers that they have the right to reinstitute substantially equivalent coverage if they have not replaced the discontinued policy with another policy or if they are subject to a waiting period for pre-existing conditions under the new policy. The notice to the former policyholders must be sent to the last available address by January 30, 1990, and must offer the beneficiary at least a 60-day period in which to request reinstitution of coverage, which would be effective January 1, 1990. In reinstituting substantially equivalent coverage, the insurer must grant the beneficiary at least the same premium classification terms that would have applied had there been no break in coverage.

Be Aware That Policies to Supplement Medicare Are Neither Sold nor Serviced by the State or Federal Governments. State insurance departments approve policies sold by insurance companies but approval only means the company and policy meet requirements of State law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program. If anyone tells you that he or she is from the government and later tries to sell you an insurance policy, report that person to your State insurance department or Federal authorities (see pages 31 to 34). This type of representation is a violation of Federal and State law.

It is also unlawful for a company or agent to falsely claim that a policy has been approved for sale in any State in which it has not received State approval, or to use fraudulent means to gain approval.

Know With Whom You're Dealing. A company must meet certain qualifications to do business in your State. This is for your protection. Agents also must be licensed by your State and may be required by the State to carry proof of licensure showing their name and the company they represent. If the agent cannot verify that he or she is licensed, do not buy from that person. A business card is not a license.

Keep Agents' and/or Companies' Names, Addresses and Telephone Numbers. Write down the agents' and/or companies' names, addresses and telephone numbers or ask for a business card that provides all that information.

Take Your Time. Do not be pressured into buying a policy by an agent who tells you that there is a limited enrollment period. Principled salespeople will not rush you. If you are not certain whether a program is worthy, ask the salesperson to explain it to a friend or relative whose judgment you respect. Allow yourself time to think through your decision.

If You Decide To Buy, Complete the Application Carefully. Some companies ask for detailed medical information. If they do and you leave out any of the medical information requested, coverage could be refused for a period of time for any medical condition you neglected to mention. The

company also could deny a claim for treatment of an undisclosed condition and/or cancel your policy. Do not believe anyone who tells you that your medical history on an application is not important.

Look for an Outline of Coverage. You must be given a clearly worded summary of the policy . . . READ IT CAREFULLY.

Do Not Pay Cash . . . pay by check, money order or bank draft made payable to the insurance company, not to the agent or anyone else.

Policy Delivery or Refunds Should be Prompt. The insurance company should deliver a policy within 30 days. If it does not, contact the company and obtain in writing the reason for the delay. If 60 days go by without information, contact your State insurance department.

Check For a "Free-Look" Provision. Insurance companies are required to give you at least 30 days to review a Medicare supplement policy. If you decide you don't want the policy, send it back to the agent or company within 30 days of receiving it and you will be entitled to a refund of all premiums you paid. Contact your State insurance department if you encounter a problem in obtaining a refund.

For Your Protection

Federal criminal and civil penalties can be imposed against any company or agent who knowingly sells you a health insurance policy that substantially duplicates coverage you already have and which will not pay

benefits if your medical expenses are covered by another insurance policy or Medicare. There are also penalties for claiming that a policy meets legal standards for Federal certification when it does not, and for using the mail for the delivery of advertisements offering for sale a Medicare supplement health insurance policy in a State in which it has not received State approval. It is also unlawful for a company or agent to suggest that they represent the Medicare program or any government agency. If you believe you have been the victim of these or any other illegal sales practices contact your State insurance department (see pages 31 to 34) or call the toll-free number maintained by the U.S. Department of Health and Human Services and listed in the front of this pamphlet.

You should also report the misuse by any individual or company of the names, letters, symbols or emblems of the U.S. Department of Health and Human Services, the Social Security Administration, and Health Care Financing Administration, or the names, letters, symbols or emblems of the programs of these agencies. Federal law prohibits the use of these agencies' and their programs' identifying marks and names or variations of them to falsely claim or suggest that they have approved, endorsed or authorized any item, including insurance policies.

TYPES OF PRIVATE HEALTH INSURANCE

Private health insurance is available through group and individual policies. It is

offered by some companies through agents and by other companies directly through advertising media and mail. Coverage offered and their values differ widely among both group and individual policies.

Types of individual and group health insurance coverages:

- **Medicare Supplement Insurance** Generally pays some or all of Medicare's deductibles and co-payments. Some policies may also pay for limited health services not covered by Medicare. The National Association of Insurance Commissioners (NAIC) has revised its model regulation to include new standards for Medicare supplement policies. These new standards require that, as a minimum, Medicare supplement policies include the following benefits:

  Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount ($592 per benefit period in 1990).

  Coverage of Part A eligible expenses for hospitalization to the extent not paid by Medicare from the 61st through the 90th day in any Medicare benefit period ($148 a day in 1990).

  Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's life-time hospital inpatient reserve days ($296 for each lifetime reserve day used in 1990).

Upon exhaustion of all Medicare hospital inpatient coverage, including lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare, subject to a lifetime maximum benefit of an additional 365 days.

Coverage for the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with Federal regulations.

Coverage for the co-payment amount (generally 20%) of Medicare eligible expenses under Part B after you pay the annual $75 Part B deductible.

To determine what minimum benefit standards are in effect in your State and whether they apply to your Medicare supplement policy, check with your State insurance department. A State may adopt minimum benefit standards that are more stringent than those in the NAIC model regulation, and they may or may not apply to your Medicare supplement policy, depending on when it was issued. Be aware, however, that these standards apply only to private policies meeting the definition of a "Medicare supplemental policy" under Federal law. That definition specifically excludes policies or plans of employers and labor organizations as well as limited benefit policies, some of which are discussed on pages 15 and 16.

Medicare pays only for services determined to be medically necessary and only the amount Medicare determines to be

reasonable (See page 27). Most Medicare supplement policies do not pay for services Medicare finds unnecessary, and some may not pay for charges in excess of Medicare's approved amount.

- **Prepayment Plans**
  There may be one or more prepayment plans such as a health maintenance organization (HMO) or competitive medical plan (CMP) in your area which participate in the Medicare program. Prepayment plans both insure health care and provide health care services. People who join are required to receive health services directly from physicians and other providers affiliated with the plan, except in an emergency when services may be furnished outside of the plan. Medicare beneficiaries are eligible to enroll in a prepayment plan only if they reside in the plan's service area and are enrolled in Medicare Part B. If you enroll in a prepayment plan, Medicare pays the plan a fixed amount each month to provide you with all Medicare-approved services. You may be required to pay the plan a monthly premium that covers the cost of deductibles and co-payments that would be your responsibility under Medicare if you were not a member of a prepayment plan. However, depending on the plan, there may not be an extra premium and the plan may offer services beyond those covered by Medicare. Services are prepaid, so usually there are no claims forms to process. If you enroll in a prepayment plan you may not need Medicare supplement insurance.

Group insurance is available through employers and voluntary associations.

- **Employer Group Insurance**

Many people are covered by a group plan while they are employed. If you have such coverage find out if it can be continued or converted to suitable individual coverage when you retire. Check the price and the benefits, including benefits for your spouse. Employer group insurance that is continued or converted after retirement usually has the advantage of having no waiting periods or preexisting condition exclusions. Consult your employer for information about special Medicare "secondary payer" rules that apply to employer group coverage for people who continue to work after they reach age 65.

If you are 65 or older and insured by an employer health plan either through your current employment or the current employment of a spouse of any age your employer plan is primary payer and Medicare is secondary payer if the employer has at least 20 employees. You have the choice of accepting or rejecting the employer plan. If you accept the employer plan it will be the primary payer of your hospital and medical bills and Medicare will be the secondary payer. This means that if the employer plan does not pay all of your expenses, Medicare may pay a portion of any unpaid charges for services covered by Medicare. If you do not accept your (or your spouse's) employer

plan, Medicare will be the primary payer of any covered health services and supplies you receive. When Medicare is the primary payer, the employer plan is not permitted to pay supplemental benefits for Medicare-covered services. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care, and physical checkups.

Medicare is also secondary to employer plan coverage for certain persons under age 65 who are entitled to Medicare based on a disability (such as employees, employers, other self-employed individuals and members of their families) and are covered by the group plan of an employer that has at least 100 employees or which participates in a multiemployer plan that provides coverage for at least one employer with 100 or more employees. Disabled persons have the same option to accept or reject the employer plan as do persons age 65 or over.

- **Association Group Insurance**

Many organizations, other than employers, offer various kinds of group health insurance coverage to their members over age 65. Beware of claims of low group rates because coverage under group policies may be as expensive or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices.

The following types of coverage are generally limited in scope and are not substitutes for Medicare supplement insurance or prepayment plans.

- Nursing Home Insurance . . . is available to cover custodial care in a nursing home and intermediate care facility (ICF). Policies also are available to pay for care in a skilled nursing facility after your Medicare benefits run out (See page 22 for a explanation of the Medicare skilled nursing care benefit). Many new insurance products covering long-term care in a nursing home have been introduced in the last few years. Some of these policies include coverage for in-home care beyond that which Medicare provides under the home health benefit.

  If you are in the market for nursing home insurance be sure you know which types of nursing homes and services are covered by the different policies available, by Medicare, and by any private insurance you may have. If you purchase nursing home or long-term care insurance (or have existing nursing home coverage) make sure it does not duplicate skilled nursing facility (SNF) coverage provided by any prepayment plan or other coverage you have.

  As you assess your need for nursing home insurance, keep in mind that custodial care in a nursing home is not covered by Medicare or most Medicare supplement policies. The majority of persons in nursing homes receive custodial care. The only care in nursing

homes that Medicare covers is skilled nursing care or skilled rehabilitation care that is provided in a SNF. Policies that cover care in a SNF usually pay only the co-payments associated with days of care for which Medicare pays. When Medicare stops paying benefits for SNF care because the patient no longer requires this level or intensity of care, private insurance may also stop paying. Check the policy for the terms of coverage.

- **Hospital Confinement Indemnity Coverage** . . . pays a fixed amount for each day you are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits.

- **Specified Disease Coverage....** (not available in some states) provides benefits for only a single disease, such as cancer, or a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Benefits are not designed to fill gaps in Medicare coverage.

WHAT MEDICARE PAYS AND DOESN'T PAY—Medicare is divided into two parts—hospital insurance (Part A) and supplementary medical insurance (Part B). Pages 18 to 24 describe Part A benefits and pages 24 through 27 describe Part B benefits.

Medicare does not pay the entire cost for all services covered by the program. You or your insurance company must pay certain deductibles and co-payments. A deductible is an initial dollar amount which Medicare does not pay. A co-payment is your share of expenses for covered services after you have paid the deductible.

The chart on pages 20 and 21 gives brief outlines of both Part A and Part B. Please refer to *The Medicare Handbook* or contact any Social Security office for more information. **The chart describes Medicare only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private coverage as described in this pamphlet.**

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

What Medicare Part A Pays

When all program requirements are met, Medicare Part A will help pay for medically necessary inpatient care in a hospital, for medically necessary inpatient care in a skilled nursing facility, and for hospice care. In addition, Part A pays the full cost of medically necessary home health care and 80% of the approved cost for durable medical equipment supplied under the home health benefit.

Part A covers all services customarily furnished by hospitals and skilled nursing facilities. Part A does not cover private duty nursing, charges for a private room, unless medically necessary, or convenience items such as a telephone or television in your room. Nor does Part A cover the first 3 pints of blood you receive during a calendar year. You cannot, however, be charged for blood if it is replaced by a blood plan or through a blood donation in your behalf or if you have met the Part B blood deductible for the calendar year. In fact, to the extent the blood deductible is met under one part of Medicare it does not have to be met under the other during the calendar year.

BENEFIT PERIODS

Medicare Part A benefits are paid on the basis of benefit periods except for the blood deductible, which is calculated on a calendar year basis. A benefit period begins the

first day you receive Medicare covered service in a hospital and ends when you have been out of a hospital or skilled nursing facility for 60 days in a row. If you enter a hospital again after 60 days, a new benefit period begins. All Part A benefits (except for any lifetime reserve days used) are renewed. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care. However, special limited benefit periods apply to hospice care (See page 24).

INPATIENT HOSPITAL CARE

Part A pays for all covered services for the first 60 days of inpatient hospital care in a benefit period except for $592, which is the hospital deductible for 1990. For the next 30 days, Part A pays for all covered services except for $148 a day. Every person enrolled in Part A also has a lifetime reserve of 60 days for inpatient hospital care. These days may be used whenever more than 90 days of inpatient hospital care are needed in a benefit period. While reserve days are being used, Part A pays for all covered services except for $296 a day. Once used, reserve days are not renewable.

Because of the change in Medicare benefits in 1990, beneficiaries who were hospitalized and paid the Medicare hospital deductible in December of 1989 and were still in the hospital on January 1, 1990, will not be liable for a new hospital deductible until their next hospital admission with a new illness.

MEDICARE (PART A): HOSPITAL INSURANC

Services	Benefit
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies	First 60 day
	61st to 90th c
	91st to 150th c
	Beyond 150 d
POSTHOSPITAL SKILLED NURSING FACILITY CARE. . .In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge. (2)	First 20 day
	Additional 80
	Beyond 100 d
HOME HEALTH CARE	Visits limited to me necessary skilled ca
HOSPICE CARE Available to terminally ill	Up to 210 days if d certifies need
BLOOD	Blood

* 60 Reserve Days may be used only once; days used are not re
** These figures are for 1990 and are subject to change each ye
*** To the extent the blood deductible is met under one part of l other part.
(1) A Benefit Period begins on the first day you receive service hospital or skilled nursing facility for 60 days in a row.
(2) Medicare and private insurance will not pay for most nursing home.

MEDICARE (PART B): MEDICAL INSURAN

Services	Benefit
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in out of the hospital
HOME HEALTH CARE	Visits limited to medically necessar care
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medic necessary
BLOOD	Blood

* Once you have had $75 of expense for covered services in 19 you receive for the rest of the year.
** YOU PAY FOR charges higher than the amount approved by approved amount as the total charge for services rendered. (S
*** To the extent the blood deductible is met under one part of other part.

)VERED SERVICES PER BENEFIT PERIOD (1)

	Medicare Pays**	You Pay**
	All but $592	$592
	All but $148 a day	$148 a day
	All but $296 a day	$296 a day
	Nothing	All costs
	100% of approved amount	Nothing
	All but $74 a day	$74 a day
	Nothing	All costs
y	Full cost of services 80% of approved amount for durable medical equipment	Nothing for services 20% of approved amount for durable medical equipment
	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
	All but first 3 pints per calendar year	For first 3 pints***

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re during the calendar year, it does not have to be met under the

patient in a hospital and ends after you have been out of the

care. You pay for custodial care and most care in a nursing

OVERED SERVICES PER CALENDAR YEAR

	Medicare Pays	You Pay
	80% of approved amount (after $75 deductible)	$75 deductible* plus 20% of approved amount (plus any charge above approved amount)**
	Full cost of services 80% of approved amount for durable medical equipment (after $75 deductible)	Nothing for services 20% of approved amount for durable medical equipment (after $75 deductible)
	80% of approved charges (after $75 deductible)	Subject to deductible plus 20% of approved amount
	80% of approved amount (after $75 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount (after $75 deductible)***

Part B deductible does not apply to any further covered services

are unless the doctor or supplier agrees to accept Medicare's
28.)
re during the calendar year, it does not have to be met under the

MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES PER BENEFIT PERIOD (1)

Services	Benefit	Medicare Pays**	You Pay**
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies	First 60 days	All but $592	$592
	61st to 90th day	All but $148 a day	$148 a day
	91st to 150th day*	All but $296 a day	$296 a day
	Beyond 150 days	Nothing	All costs
POSTHOSPITAL SKILLED NURSING FACILITY CARE. . .In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge. (2)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $74 a day	$74 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE	Visits limited to medically necessary skilled care	Full cost of services 80% of approved amount for durable medical equipment	Nothing for services 20% of approved amount for durable medical equipment
HOSPICE CARE Available to terminally ill	Up to 210 days if doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Blood	All but first 3 pints per calendar year	For first 3 pints***

* 60 Reserve Days may be used only once; days used are not renewable.
** These figures are for 1990 and are subject to change each year.
*** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.
(1) A Benefit Period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.
(2) Medicare and private insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home.

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES PER CALENDAR YEAR

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of the hospital	80% of approved amount (after $75 deductible)	$75 deductible* plus 20% of approved amount (plus any charge above approved amount)**
HOME HEALTH CARE	Visits limited to medically necessary care	Full cost of services 80% of approved amount for durable medical equipment (after $75 deductible)	Nothing for services 20% of approved amount for durable medical equipment (after $75 deductible)
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary	80% of approved charges (after $75 deductible)	Subject to deductible plus 20% of approved amount
BLOOD	Blood	80% of approved amount (after $75 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount (after $75 deductible)***

Once you have had $75 of expense for covered services in 1990, the Part B deductible does not apply to any further covered services you receive for the rest of the year.
YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered. (See page 28.)
To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

SKILLED NURSING FACILITY CARE

Part A can help pay for up to 100 days of extended care services in a skilled nursing facility (SNF) during a benefit period. All approved amounts for the first 20 days of care are fully paid by Medicare. All approved amounts for the next 80 days are paid by Medicare except for a daily co-payment which is the responsibility of the beneficiary. The daily co-payment in 1990 is $74. It is subject to change annually.

To qualify for Medicare coverage for SNF care you must have been in a hospital at least three consecutive days (not counting the day of discharge) before entering a SNF. The admission generally must be within 30 days of your discharge from the hospital, your physician must certify that you need the care and it must be for the condition for which you were treated in the hospital.

A SNF is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility, such as a hospital or an intermediate care facility (ICF). Medicare benefits are payable only if you require a skilled level of care and the care is provided in a SNF certified by Medicare. Many nursing homes in the United States are not SNFs and many SNFs are not certified by Medicare. Medicare will not pay for your stay in a SNF if the services you receive are mainly personal care or custodial services, such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

Because the three-day prior hospitalization requirement and the benefit-period system were not in effect in 1989, special rules apply to Medicare beneficiaries who received extended care services from a SNF from 1989 into 1990. They will not be required to meet the three-day prior hospitalization requirement until they have not received inpatient hospital or extended care services for 30 consecutive days. After that, they will have to meet the prior hospitalization requirement in order to qualify for additional days of covered extended care services.

HOME HEALTH CARE

Part A pays the cost of medically necessary home health visits for homebound beneficiaries. Coverage includes the intermittent services of a skilled nurse, and the services of physical and speech therapists when furnished through a Medicare-certified home health agency. If you require any of these services and are confined to your home and are under the care of a physician, Part A can also cover reasonable and necessary part-time or intermittent home health aide and skilled nursing services, occupational therapy, medical social services, medical supplies and a portion of the cost of durable medical equipment provided under a plan of care established and periodically reviewed by a physician. Part A does not cover full-time nursing care, drugs, meals delivered to your home or homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

HOSPICE CARE

Medicare beneficiaries certified as terminally ill may elect to receive hospice care under Part A in lieu of regular Medicare. Part A can pay for two 90-day hospice benefit periods and one 30-day period, for a total of 210 days of care.

Beneficiaries enrolled in a Medicare-certified hospice program receive medical and support services necessary for symptom management and pain relief. When these services are provided by a Medicare-certified facility, the coverage includes: physician services, nursing care, medical appliances and supplies (including outpatient drugs for symptom management and pain relief), short-term inpatient care, counseling, therapies, and home health aide and homemaker services. There is no deductible. Patients must pay only limited cost-sharing for outpatient drugs and inpatient respite care. In the event the patient requires medical services for a condition unrelated to the terminal illness, regular Medicare benefits are available.

MEDICARE MEDICAL INSURANCE BENEFITS (PART B)

What Medicare Part B Pays.

Medicare Part B helps pay for physician and various other medical services and supplies. You are automatically enrolled in Part B when you enroll in Part A unless you state that you don't want it.

YOU DO NOT HAVE TO PURCHASE PART B BUT IT IS AN EXCELLENT BUY BECAUSE THE FEDERAL GOVERNMENT

PAYS ABOUT 75 PERCENT OF THE ACTUAL COST. IF YOU DO NOT NOW HAVE PART B COVERAGE AND YOU WANT IT, YOU MAY ENROLL DURING THE GENERAL ENROLLMENT PERIOD FROM JANUARY 1 THROUGH MARCH 31 EACH YEAR. IT IS AVAILABLE TO YOU REGARDLESS OF WHETHER YOU QUALIFY FOR PART A. IF YOU ARE COVERED UNDER YOUR OR YOUR SPOUSE'S EMPLOYER GROUP HEALTH PLAN, YOU MAY ENROLL IN PART B WHEN THE EMPLOYMENT ON WHICH THIS COVERAGE IS BASED COMES TO AN END, OR WHEN THE PLAN IS TERMINATED, WHICHEVER OCCURS FIRST.

When you use your Part B benefits, you will be required to pay the first $75 (the annual deductible) of charges approved by Medicare. After that, Medicare Part B generally pays 80 percent and you pay 20 percent of the approved amount for covered services you receive the rest of the year.

SERVICES COVERED BY PART B

- Physicians' and surgeons' services no matter where you receive them . . . at home, in the doctor's office, in a clinic or hospital. Routine physical exams are not covered.

- Home health visits. If you do not have Medicare Part A, then Part B pays for medically necessary covered home health visits for patients that meet the qualifying criteria as set forth for Medicare coverage of home health services. You have no deductible or co-payment

except for 20% of the cost of durable medical equipment supplied under the home health benefit.

- Physical therapy and speech pathology services in a doctor's office, as an out patient, or in your home.

- Outpatient prescription drugs furnished hospice enrollees, non-self administerable drugs which are provided incident to physician services and immunosuppressives provided during the first year after an organ transplant.

- Other medical services and supplies, including outpatient hospital services, X-rays and laboratory tests, certain ambulance services, and the purchase or rental of durable medical equipment, such as wheelchairs.

EXPENSES NOT COVERED BY MEDICARE--Medicare does not cover certain kinds of care, charges or supplies. Among them are:

- Private duty nursing.

- Skilled nursing home care costs beyond 100 days per benefit period.

- Custodial nursing home care.

- Intermediate nursing home care.

- Physician charges above Medicare's approved amount.

- Most outpatient prescription drugs.

- Care received outside the USA, except under limited circumstances in Canada and Mexico.

- Dental care or dentures, checkups, most routine immunizations, cosmetic surgery, routine foot care, examinations for and the cost of eyeglasses or hearing aids.

Part B will not pay for any services which Medicare does not consider medically necessary . . . nor will most insurance policies.

APPROVED AMOUNT

In deciding whether a charge is "reasonable," Medicare reviews each year the usual charges of doctors or suppliers for each covered service and the charges of other doctors and suppliers in the area for the same service. The amount approved in payment for a claim is often lower than the actual charge made by the doctor or supplier.

Many Medicare supplement insurance policies pay only the Medicare co-payment that you are responsible for; that is, 20% of Medicare's approved amount. You might not get 100% coverage for your Part B bills even if you have Medicare Part B and private insurance. Here's how that could happen:

Suppose your doctor charges you $400 for an operation. And suppose the amount Medicare has approved for that particular operation is $300. Assuming you have already met the annual $75 Part B

deductible, Medicare would pay 80% of the $300 approved amount, or $240. Many insurance policies would pay your 20% share of the $300 approved amount, or $60. That would leave a balance of $100 that you would have to pay out of your own pocket. You can avoid having to pay more than the Medicare approved amount by using doctors and medical suppliers who accept assignment.

ASK ABOUT ASSIGNMENT AND PARTICIPATING DOCTORS OR SUPPLIERS

Because you can't tell in advance whether the approved amount and the actual charge for covered services and supplies will be the same, always ask your doctors or medical suppliers, such as laboratories and therapists, if they accept assignment of Medicare benefits. Assignment means that the doctor or supplier will accept Medicare's approved amount as full payment and cannot legally bill you for anything above that amount. All physicians and qualified laboratories must accept assignment for covered clinical diagnostic laboratory tests.

While some doctors and suppliers accept assignment on a case-by-case basis, others have agreed to participate in Medicare and accept assignment on all Medicare claims. Their names and addresses are listed in *The Medicare Participating Physician/ Supplier Directory* that is distributed to senior citizen organizations, all local Social Security and Railroad Retirement offices, all hospitals, and all State and area offices of The Administration on Aging. The directory may be obtained free of charge from the

insurance carrier that processes Medicare Part B claims in your area (see the back of *The Medicare Handbook* for the list of carrier addresses), or you can call the carrier to find out which doctors and suppliers are participating.

PAYING FOR MEDICARE--Part A is financed through part of the Social Security (FICA) tax paid by all workers and their employers. You do not have to pay a monthly premium for Medicare Part A if you or your spouse are entitled to benefits under either the Social Security or Railroad Retirement systems, or worked a sufficient period of time in Federal, State, or local government employment to be insured. Some disabled persons who do not meet the age requirement of 65 may also qualify for benefits. If you do not meet the qualifications for premium-free Part A benefits and you are at least 65 years old, you may purchase the coverage. The monthly premium is $175 in 1990.

PART B MONTHLY PREMIUM

Part B is optional and is offered to all beneficiaries when they enroll in Part A. It also may be purchased by individuals who do not qualify for Part A. The monthly Part B premium is $28.60 in 1990.

FOR ADDITIONAL HELP

If you need additional help or advice on Medicare benefits or eligibility, contact your nearest Social Security office or the Medicare insurance carrier in your area.

For information on private insurance to supplement Medicare, check your State insurance department or State agency on aging. (See the lists in the back of this pamphlet.)

If you bought or are considering buying a health insurance policy, the company or its agent should answer your questions. If you do not get the service you feel you deserve, discuss the matter with your State insurance department.

STATE INSURANCE DEPARTMENTS

Each State has its own laws and regulations governing all types of insurance. The offices listed in this section are responsible for enforcing these laws, as well as providing the public with information about insurance.

Alabama
Alabama Insurance Department
135 South Union Street
Montgomery, AL 36130-3401
(205) 269-3550

Alaska
Alaska Insurance Department
3601 C Street, Suite 740
Anchorage, AK 99503
(907) 562-3626

American Samoa
American Samoa Insurance Department
Office of the Governor
Pago Pago, AS 96797
011-684/633-4116

Arizona
Arizona Insurance Department
Consumer Affairs and Investigation Division
3030 N. Third Street
Phoenix, AZ 85012
(602) 255-4783

Arkansas
Arkansas Insurance Department
Consumer Service Division
400 University Tower Bldg.
12th and University Streets
Little Rock, AR 72204
(501) 371-1813

California
California Insurance Department
Consumer Services Division
3450 Wilshire Boulevard
Los Angeles, CA 90010
1-800-233-9045

Colorado
Colorado Insurance Division
303 W. Colfax Avenue, 5th Floor
Denver, CO 80204
(303) 620-4300

Connecticut
Connecticut Insurance Department
165 Capitol Avenue
State Office Building
Hartford, CT 06106
(203) 297-3800

Delaware
Delaware Insurance Department
841 Silver Lake Boulevard
Dover, DE 19901
(302) 736-4251

District of Columbia
District of Columbia Insurance
613 G Street, NW
Room 619
P.O. Box 37200
Washington, DC 20001-7200
(202) 727-8017

Florida
Florida Department of Insurance
State Capitol
Plaza Level Eleven
Tallahassee, FL 32399-0300
Toll Free (Within State)
1-800-342-2762
(904) 488-0030

Georgia
Georgia Insurance Department
2 Martin L. King, Jr., Dr.
Room 716 West Tower
Atlanta, GA 30334
(404) 656-2056

Guam
Guam Insurance Department
855 W. Marine Drive
P.O. Box 2796
Agana, Guam 96910
011-671/477-1040

Hawaii
Hawaii Department of Commerce and Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, HI 96811
(808) 548-5450

Idaho
Idaho Insurance Department
Public Service Department
500 S. 10th Street
Boise, ID 83720
(208) 334-3102

Illinois
Illinois Insurance Department
320 W. Washington Street
4th Floor
Springfield, Il 62767
(217) 782-4515

Indiana
Indiana Insurance Department
311 W. Washington Street
Suite 300
Indianapolis, IN 46204
(317) 232-2395

Iowa
Iowa Insurance Division
Lucas State Office Bldg.
E. 12th & Grand Sts.
6th Floor
Des Moines, IA 50319
(515) 281-5705

Kansas
Kansas Insurance Department
420 S.W. 9th Street
Topeka, KS 66612
(913) 296-3071

Kentucky
Kentucky Insurance Department
229 West Main Street
P.O. Box 517
Frankfort, KY 40602
(502) 564-3630

Louisiana
Louisiana Insurance Department
P.O. Box 94214
Baton Rouge, LA 70804-9214
(504) 342-5900

Maine
Maine Bureau of Insurance
Consumer Division
State House, Station 34
Augusta, ME 04333
(207) 582-8707

Maryland
Maryland Insurance Department
Complaints and Investigation Unit
501 St. Paul Place
Baltimore, MD 21202-2272
(301) 333-2792

Massachusetts
Massachusetts Insurance Division
Consumer Services Section
280 Friend Street
Boston, MA 02114
(617) 727-7189

Michigan
Michigan Insurance Department
P.O. Box 30220
Lansing, MI 48909
(517) 373-0220

Minnesota
Minnesota Insurance Department
Department of Commerce
133 E. 7th Street
St. Paul, MN 55101
(612) 296-4026

Mississippi
Mississippi Insurance Department
Consumer Assistance Division
P.O. Box 79
Jackson, MS 39205
(601) 359-3569

Missouri
Missouri Division of Insurance
Consumer Services Section
P.O. Box 690
Jefferson City, MO
65102-0690
(314) 751-2640

Montana
Montana Insurance Department
126 N. Sanders
Mitchell Building
P.O. Box 4009, Room 270
Helena, MT 59604
Toll-Free (Within State)
1-800-332-6148
(406) 444-2040

Nebraska
Nebraska Insurance Department
Terminal Building
941 O Street, Suite 400
Lincoln, NE 68508
(402) 471-2201

Nevada
Nevada Department of Commerce
Insurance Division
Consumer Section
1665 Hot Springs Road
Capitol Complex
Carson City, NV 89701
(702) 687-4270

New Hampshire
New Hampshire Insurance
Department
Life and Health Division
169 Manchester Street
Concord, NH 03301
(603) 271-2261

New Jersey
New Jersey Insurance Department
20 W. State Street
Roebling Building
Trenton, NJ 08625
(609) 292-4757

New Mexico
New Mexico Insurance Department
P.O. Box 1269
Santa Fe, NM 87504-1269
(505) 827-4500

New York
New York Insurance Department
160 W. Broadway
New York, NY 10013
New York City
(212) 602-0203
Toll Free (Within State outside of NYC)
1-800-342-3736

North Carolina
North Carolina Insurance Department
Consumer Services
Dobbs Building
P.O. Box 26387
Raleigh, NC 27611
(919) 733-2004

North Dakota
North Dakota Insurance Department
Capitol Building
5th Floor
Bismarck, ND 58505
(701) 224-2440

Ohio
Ohio Insurance Department
Consumer Services Division
2100 Stella Court
Columbus, OH 43266-0566
(614) 644-2673

Oklahoma
Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK
73152-3408
(405) 521-2828

Oregon
Oregon Department of Insurance and Finance
Insurance Division/Consumer Advocate
21 Labor and Industry Bldg.
Salem, OR 97310
(503) 378-4484

Pennsylvania
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, PA 17120
(717) 787-2317

Puerto Rico
Puerto Rico Insurance Department
Fernandez Juncos Station
P.O. Box 8330
Santurce, PR 00910
(809) 722-8686

Rhode Island
Rhode Island Insurance Division
233 Richmond Street
Suite 233
Providence, RI 02903-4233
(401) 277-2223

South Carolina
South Carolina Insurance Department
Consumer Assistance Section
P.O. Box 100105
Columbia, SC 29202-3105
(803) 737-6140

South Dakota
South Dakota Insurance Department
Enforcement
910 E. Sioux Avenue
Pierre, SD 57501-3940
(605) 773-3563

Tennessee
Tennessee Department of Commerce and Insurance
Policyholders Service Section
4th Floor
500 James Robertson Parkway
Nashville, TN 37243-0582
Toll-Free (Within State)
1-800-342-4029
(615) 741-4955

Texas
Texas Board of Insurance
Complaints Division
1110 San Jacinto Blvd.
Austin, TX 78701-1998
(512) 463-6501

Utah
Utah Insurance Department
Consumer Services
3110 State Office Bldg.
Salt Lake City, UT 84114
(801) 530-6400

Vermont
Vermont Department of Banking
and Insurance
Consumer Complaint Division
120 State Street
Montpelier, VT 05602
(802) 828-3301

Virgin Islands
Virgin Islands Insurance
Department
Kongens Garde No. 18
St. Thomas, VI 00802
(809) 774-2991

Virginia
Virginia Insurance Department
Consumer Services Division
700 Jefferson Building
P.O. Box 1157
Richmond, VA 23209
(804) 786-7691

Washington
Washington Insurance
Department
Insurance Building AQ21
Olympia, WA 98504-0321
Toll Free (Within State)
1-800-562-6900
(206) 753-7300

West Virginia
West Virginia Insurance
Department
2019 Washington Street, E
Charleston, WV 25305
(304) 348-3386

Wisconsin
Wisconsin Insurance Department
Complaints Department
P.O. Box 7873
Madison, WI 53707
(608) 266-0103

Wyoming
Wyoming Insurance Department
Herschler Building
122 W. 25th Street
Cheyenne, WY 82002
(307) 777-7401

The offices listed in this section are responsible for coordinating services for older Americans.

Alabama
Commission on Aging
136 Catoma Street
Montgomery, AL 36130
Toll Free (Within State)
1-800-243-5463
(205) 242-5743

Alaska
Older Alaskans Commission
P.O. Box C, MS 0209
Juneau, AK 99811
(907) 465-3250

American Samoa
Territorial Administration on Aging
Government of American Samoa
Pago Pago, AS 96799
(684) 633-1251

Arizona
Department of Economic Security
Aging and Adult Administration
1400 W. Washington Street
Phoenix, AZ 85007
(602) 542-4446

Arkansas
Division of Aging and Adult Services
Donaghey Plaza South
Suite 1417
7th and Main Streets
P.O. Box 1417/Slot 1412
Little Rock, AR 72203-1437
(501) 682-2441

California
Department of Aging
1600 K Street
Sacramento, CA 95814
(916) 322-3887

Colorado
Aging and Adult Services
Department of Social Services
1575 Sherman St., 10th Floor
Denver, CO 80203-1714
(303) 866-3851

Commonwealth of the Northern Mariana Islands
Department of Community and Cultural Affairs
Civic Center
Commonwealth of the Northern Mariana Islands
Saipan, CM 96950
(670) 234-6011

Connecticut
Department on Aging
175 Main Street
Hartford, CT 06106
Toll Free (Within State)
1-800-443-9946
(203) 566-7772

Delaware
Division of Aging
Department of Health and Social Services
1901 N. DuPont Highway
New Castle, DE 19720
(302) 421-6791

District of Columbia
Office on Aging
Executive Office of the Mayor
1424 K Street, NW
2nd Floor
Washington, DC 20005
(202) 724-5626
(202) 724-5622

Federated States of Micronesia
State Agency on Aging
Office of Health Services
Federated States of Micronesia
Ponape, E.C.I. 96941

Florida
Office of Aging and Adult Services
1317 Winewood Boulevard
Tallahassee, FL 32301
(904) 488-8922

Georgia
Office of Aging
Department of Human Resources
878 Peachtree Street, NE
Room 632
Atlanta, GA 30309
(404) 894-5333

Guam
Division of Senior Citizens
Department of Public Health
and Social Services
P.O. Box 2816
Agana, GU 96910
(671) 734-2942

Hawaii
Executive Office on Aging
335 Merchant Street
Room 241
Honolulu, HI 96813
(808) 548-2593

Idaho
Office on Aging
Statehouse, Room 114
Boise, ID 83720
(208) 334-3833

Illinois
Department on Aging
421 E. Captiol Avenue
Springfield, IL 62701
(217) 785-2870

Indiana
Department of Human Services
251 North Illinois
P.O. Box 7083
Indianapolis, IN 46207-7083
(317) 232-7020

Iowa
Department of Elder Affairs
Suite 236, Jewett Building
914 Grand Avenue
Des Moines, IA 50319
(515) 281-5187

Kansas
Department on Aging
122-S, Docking State Office
Building
915 SW Harrison
Topeka, KS 66612-1500
(913) 296-4986

Kentucky
Division for Aging Services
Department for Social Services
275 E. Main Street
Frankfort, KY 40621
(502) 564-6930

Louisiana
Governor's Office of Elderly Affairs
P.O. Box 80374
Baton Rouge, LA 70898-0374
(504) 925-1700

Maine
Maine Committee of Aging
State House, Station 127
Augusta, ME 04333
(207) 289-3658

Maryland
State Agency on Aging
301 W. Preston Street
Baltimore, MD 21201
(301) 225-1102

Massachusetts
Executive Office of Elder Affairs
38 Chauncy Street
Boston, MA 02111
Toll Free (Within State)
1-800-882-2003
(617) 727-7750

Michigan
Office of Services to the Aging
P.O. Box 30026
Lansing, MI 48909
(517) 373-8230

Minnesota
Minnesota Board on Aging
Human Services Building
4th Floor
444 Lafayette Road
St. Paul MN 55155-3843
(612) 296-2770

Mississippi
Council on Aging
301 W. Pearl Street
Jackson, MS 39203-3092
Toll Free (Within State)
1-800-222-7622
(601) 949-2070

Missouri
Division of Insurance
Truman Building 630
P.O. Box 690
Jefferson, MO 65102-0690
Toll Free (Within State)
1-800-235-5503

Montana
Department of Family Services
P.O. Box 8005
Helena, MT 59604
(406) 444-5900

Nebraska
Department on Aging
Legal Services Developer
State Office Building
301 Centennial Mall South
Lincoln, NE 68509
(402) 471-2306

Nevada
Department of Human Resources
Division for Aging Services
505 E. King Street
Room 101
Carson City, NV 89710
(702) 885-4210

New Hampshire
Department of Health and
Human Services
Division of Elderly and Adult
Services
6 Hazen Drive
Concord, NH 03301
(603) 271-4394

New Jersey
Department of Community Affairs
Division on Aging
S. Broad and Front Sts.
CN 807
Trenton, NJ 08625-0807
(609) 292-0920

New Mexico
Agency on Aging
La Villa Rivera Bldg.
4th Floor
224 E. Palace Avenue
Santa Fe, NM 87501
Toll Free (Within State)
1-800-432-2080
(505) 827-7640

New York
State Office for the Aging
Agency Building
2 Empire State Plaza
Albany, NY 12223-0001
Toll Free (Within State)
1-800-342-9871
(518) 474-5731

North Carolina
Department of Human Resources
Division of Aging
1985 Umstead Drive
Raleigh, NC 27603
(919) 733-3983

North Dakota
Department of Human Services
Aging Services Division
State Capitol Building
Bismarck, ND 58505
(701) 224-2577

Ohio
Department of Aging
50 W. Broad Street
8th Floor
Columbus, OH 43266-0501
(614) 466-1221

Oklahoma
Department of Human Services
Aging Services Division
P.O. Box 25352
Oklahoma City, OK 73125
(405) 521-2327

Oregon
Department of Human Resources
Senior Services Division
313 Public Service Building
Salem, OR 97310
Toll Free (Within State)
1-800-232-3020
(503) 378-4636

Palau
State Agency on Aging
Department of Social Services
Republic of Palau
Koror, Palau 96940

Pennsylvania
Department of Aging
231 State Street
Barto Building
Harrisburg, PA 17101
(717) 783-1550

Puerto Rico
Governors Office of Elderly Affairs
Gericulture Commission
Box 11398
Santurce, PR 00910
(809) 722-2429 or 722-0225

Republic of the Marshall Islands
State Agency on Aging
Department of Social Services
Republic of the Marshall Islands
Marjuro, Marshall Islands 96960

Rhode Island
Department of Elderly Affairs
160 Pine Street
Providence, RI 02903
(401) 277-2858

South Carolina
Commission on Aging
400 Arbor Lake Drive
Suite B-500
Columbia, SC 29223
(803) 735-0210

South Dakota
Agency on Aging
Adult Services and Aging
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3656

Tennessee
Commission on Aging
706 Church Street
Suite 201
Nashville, TN 37219-5573
(615) 741-2056

Texas
Department on Aging
P.O. Box 12786
Capitol Station
Austin, TX 78711
(512) 444-2727

Utah
Division of Aging & Adult Services
120 North 200 West
P.O. Box 45500
Salt Lake City, UT 84145-0500
(801) 538-3910

Vermont
Office on Aging
Waterbury Complex
103 S. Main Street
Waterbury, VT 05676
(802) 241-2400

Virgin Islands
Department of Human Services
Barbel Plaza South
Charlotte Amalie
St. Thomas, VI 00802
(809) 774-0930

Virginia
Department for the Aging
700 Centre, 10th Floor
700 E. Franklin Street
Richmond, VA 23219-2327
Toll Free (Within State)
1-800-552-4464
(804) 225-2271

Washington
Aging & Adult Services
Administration
Department of Social & Health
Services
Mail Stop OB-44-A
Olympia, WA 98504
(206) 586-3768

West Virginia
Commission on Aging
State Capitol Complex
Holly Grove
Charleston, WV 25305
Toll Free (Within State)
1-800-642-3671
(304) 348-3317

Wisconsin
Bureau on Aging
Department of Health & Social
Services
P.O. Box 7851
Madison, WI 53707
Toll Free (Within State)
1-800-242-1060
(608) 266-2536

Wyoming
Commission on Aging
Hathaway Building
First Floor
Cheyenne, WY 82002
Toll Free (Within State)
1-800-442-2766
(307) 777-7986

POLICY CHECK-LIST

After reading this guide, you may find this check-list useful in assessing the benefits provided by a Medigap policy or in comparing policies.

Does the policy cover:	YES	NO
Medicare Part A hospital deductible?	☐	☐
Medicare Part A hospital daily co-payments?	☐	☐
Hospital Care Beyond Medicare's limits	☐	☐
Medicare Part B annual deductible?	☐	☐
Medicare Part B co-payments? . .	☐	☐
Medicare blood deductibles? . .	☐	☐
Private hospital room?	☐	☐
Private hospital nurses?	☐	☐
Medical appliances such as eyeglasses and hearing aids? . .	☐	☐
Custodial nursing home care? . .	☐	☐
Is there a coordination of benefits provision?	☐	☐
Can the company cancel or non-renew the policy?	☐	☐
What are the policy limits for covered services?	—	—
What health conditions are excluded under the policy? . . .	—	—
How often can the company raise the premium?	—	—
How long before existing health problems are covered? . .	—	—
Does the policy have a waiting period? How long?	—	—

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration
Publication No. HCFA 02110

GPO : 1990 O - 266-579 : QL 3

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
6325 Security Boulevard
Baltimore, Maryland 21207

U.S. Department of Health and Human Services
Health Care Financing Administration
Publication No. HCFA 02110
1990